

# Negligence in midwifery



**ASSIGN  
BUSTER**

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After a spontaneous vaginal delivery a woman suffered a severe haemorrhage leading to hypovolaemia and severe adult respiratory distress. She was admitted to an Intensive Care Unit but had recurrent bleeding, then collapsed. After resuscitation in theatre, a substantial piece of placental tissue was removed under general anaesthesia. Upon routine checking the staff midwife was initially doubtful about the placenta, but then she documented that the placenta was complete. Discuss.

### Introduction

A practising registered midwife is an accountable person who ensures that health and safety laws are implemented in her care provided (Dimond, 2002 pg. 312). The registered midwife puts into priority the safety of the mother and her baby. The competent midwife is knowledgeable, understanding, skilled, and accountable. Unfortunately any behaviour that the research based professional carries out or fails to carry out, that result in harm to the mother or the child will have legal implications (Dimond, 2002).

### Postpartum haemorrhage

Uncontrolled bleeding of more than 500mls from the women's genital tract, at any time following delivery to 12 weeks postpartum is described as postpartum haemorrhage (Williams, 2011 pg. 113). Blood lost can be either evident or concealed, resulting in shock (Tiran, 2012). Postpartum haemorrhage is the most common cause of maternal death occurring worldwide (Fraser & Cooper, 2009). Optimum management of the third and fourth stage of labour is a matter of great concern towards preserving

maternal health. Postpartum haemorrhage is most often a case of inappropriate management of the third stage of labour, along with an unprofessional inspection of the placenta (Fraser & Cooper, 2009).

### Examination of the placenta

Inspection of the placenta is a practical examination done in the labouring room by a fully qualified midwife. This exam includes the assessment of both the fetal and maternal membranes. Evaluation of the placenta is part of the duty of care of the midwife in the first hour following birth. On the delivery of the placenta, either by expectant or active management of the third stage, the midwife holds up the placenta from the umbilical cord with the fetal surfaces being examined first. The membranes are examined for integrity, completeness and any present abnormalities. Membranes; the amnion and the chorion should be made sure to be present and complete (De Kock, 2004).

This assessment is usually done in the presence of the mother. The maternal surface is examined for completeness, so as to make sure that no cotyledons have been left inside the uterus. If a cotyledon is found to be missing, or if the midwife is uncertain with regards to placental findings, help from other health professionals should be sought and the placenta kept for further examination. Of utmost importance is to include the mother in the examination, describing reasons for the examination procedure, while explaining the possible risks of an incomplete placenta (De Kock, 2004).

### Women's right for information

The mother has the right to be informed of both the normal and abnormal findings. Communication is a necessary tool in midwifery. While being close to the woman, the midwife should have explained the situation and kept the mother calm, while talking her through the necessary procedures that were to take place (ICM, 2011)

### The midwife

The title ‘ midwife’ can only be used by the “person who has successfully completed a midwifery educational programme, that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of ICM Global Standards for Midwifery Education : who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘ midwife’; and who demonstrates competency in the practice of midwifery” (Midwives code of practice, 2005).

### The core competencies of the midwife

The midwife is fit to practise if she has the necessary knowledge and skills, has a good professional behaviour, character and a good health status, meeting the standards and competencies required (ICM, 2011).

Competencies are set up as a guide for midwives to fulfil their profession. The guidelines provided by the code of practise in midwifery, aims to put in priority the safety of the mother and the child. The competencies of the expert of normality include her ability to work with the women and provide constant care and support.

Being competent means, that a high quality care and a cultural sensitive assistance is given to the mother during birth. Such event is the monitoring of the fetal and maternal wellbeing and providing the assistance towards performing a safe birth. The midwife must be aware of the possible risks occurring during labour being able to observe, recognize and act when warning signs present (ICM, 2011).

#### Being competent and accountable- the case scenario

The skills and abilities allow the midwife to inspect the placenta for integrity and completeness, however, in such a case as described above, having a midwife not sure of herself, referral to other health care professionals should have been considered while assisting the latter if possible.

Having the mother notified of the findings and given consent with relation to the procedures that needed to take place, appropriate analgesia should have been administered. Once the doctor confirms that a part of the placenta is missing, a vaginal exam followed by an examination of the uterus under sterile conditions is usually performed. Should the midwife acted as a responsible professional, she must have been in control to take the necessary urgent measures if help from other health professionals was not accessible, keeping in mind the risk against the benefits.

In such a case the priority of the midwife should have been managing postpartum bleeding so as to avoid the incidence of haemorrhage (ICM, 2011). The skills and abilities of the midwife allow her to perform a fundal massage in order to stimulate a contraction and help any remaining clots left in the uterine or vaginal cavity to be delivered (De Kock, 2004). Of utmost

importance in the delivering the appropriate care, was the monitoring and estimation of the maternal blood loss. Oxytocic drugs should have been administered while regularly assessing vital signs of the mother, in addition to the recording of concise and accurate data of the events (ICM, 2011).

In such a case were haemorrhage occurred, lifesaving drugs could have been administered to the woman in order for shock and respiratory distress to be avoided. The midwife shall have the skill to identify shock and be able to manage it. An intravenous line should have been inserted in such case and while administering the appropriate fluids and drugs, drawing of blood for laboratory testing could have been made possible. The woman with serious complication needed to be transferred to a higher level of care so as for emergency care to be given as required. In extreme cases the midwife must be able to perform cardio pulmonary resuscitation (De Kock, 2004).

Furthermore, following such care, the midwife must have given great importance to the postnatal period of the woman. Observations of the woman's progress and monitoring of the vital signs should have taken place (ICM, 2011).

#### Record Keeping- A professional tool

Accurate documentation of the process of labour and birth is a responsible role of the midwife. Appropriate written information about the progress of labour and the on-going care provided during this experience, gives out relative information about the mother and the fetal well-being during the birth events. The midwife must ensure that all the records are filled appropriately before transferring the woman to the future health care

professionals (De Kock, 2004). The purpose of documentation is to provide a written evidence of events as they take place (Dimond, 2002).

Appropriate written communication in the event of labour shall be factual, well dictated, concise, consistent, accurate, clear, legible, relevant and signed. Writing shall include detailed information of the care provided, the plan, actions, observations and the events occurring during labour (Dimond, 2002) All the information being documented is to be written as a contemporaneous manner of events. Documenting childbirth is a description of the birthing process. Relative information shall include data of the estimated blood loss during labour, the findings from the placenta examination as well as the results of the mother's vital signs, whenever taken during the mother's stay. Assessment of the perineum and vagina along with identification of necessary repairs, type and quantity of sutures required should also be noted (Dimond, 2002). The midwife must preserve all information recorded. Keeping all the records provides guidance to the health professional (Dimond, 2002). Documentation is a tool in the experts practise and it shall be considered as an essential part of care and not as additional to the care offered (Dimond, 2002)

When writing out records one is to eliminate abbreviations and write in a manner that is easily understood by others. Records shall be clear so as to serve as a tool to facilitate an investigation. If any mistake is present in the recording of information, this should be corrected by cutting out neatly the mistake, while making sure that a signature and a date is presented. All information recorded by students is to be seen and signed by the midwife assigned. Information is to be written in a consecutive manner, having

problems arising during the birth identified, and the actions and plans noted (Dimond, 2002). Regular training on documentation shall be proposed especially in situations where pressure is present especially at the time of the delivery where time is limited and record keeping is given a low priority. Written information shall reflect a clear evidence of the care being constantly provided to the mother and the baby (Dimond, 2002)

“A record becomes a legal document whenever it is required as an evidence of events occurred and is relevant in a court of law” (Dimond, 2002). Tools of documentation are necessary in the court of law, as although they are not always a proof of truth; records are an instrument of evidence and are tool for criticism by the judge. All written records are to be accurately dated timed, and signed.

### Negligence

‘ Negligence may be best defined as actionable harm where a patient claims compensation caused by the carelessness of a midwife in breach of their duty of care’ (Griffith, 2008).

Negligence is the failure to take care of someone or something. This is the most brought up action in health services for compensation (Dimond, 2002 pg. 182). Compensation can only be given when the midwife infringed the law in her duty of care, when harm has been recognised, or in the presence of a negative result that had been led to by the disrupted duty of care.

The midwife has the responsibility of the duty of care towards all her clients. The duty of care involves: caring safely for the women and family, being able



to communicate effectively, sharing evidence based information, giving advice, notifying the women of risks and acting in a way to promote health (Dimond, 2002 pg. 184). The duty of care does not only relate to the care and treatment, but includes also the act of recording factual information and storing records. Duty of care involves all actions and activities that ensure safety. The midwife must aim to avoid acts that put the person at risk of harm. The person described is one who is directly affected by the midwife act. The aim is to have a positive effect on the mother, new-born, family and the overall experience (Dimond, 2002 pg. 185). When a midwife is found guilty of putting the mother close to death a custodial sentence is most likely to be received by midwife (Griffith, 2010).

#### Legislation of care

This case scenario is a typical example of a dispute in the legal duty of care. In this case the midwife must have first understood the present standards of care (Dimond, 2002). The midwife described here has failed to understand and follow the protocols, guidelines and procedures drawn up nationally and locally. The midwife has also failed to understand the importance of accurate record keeping. The midwife is challenged on her inappropriate actions. Her records, if written precisely can also aid in defending her actions (Griffith, 2010).

As a general rule, midwives who are not certain about the changing and revised standards of care, being practised in the area, are to make sure that all necessary information is gathered, understood and followed, so as to enhance safety in the care given to the mother and the family (Griffith,

2008). All midwives are responsible to obey to all policies. Trained and competent midwives are trusted and the element of trust in a qualified midwife reflects her level of competencies (Dimond, 2002).

The government aims to increase the standard of the registered professionals and makes sure that all practitioners listed on the registration list are safe and protective towards the public.

Legislation aims to protect the mothers from dangerous professional staff. When a professional staff identifies that she has made a mistake, she shall not be complacent. It is the role of the midwife to communicate effectively with the woman and give all the acknowledgment, explanations and apologies, so as to act in the best way to correct her behaviour towards safeguarding the women and her family (Dimond, 2002 pg. 220).

Although health professionals are to be knowledgeable and assertive, being over confident with their behaviour might put the mother and child at risk. With regard to this case scenario, having the midwife not seeking help from other professionals signifies, that her over confidence has led her to reduce the quality of care provided. Furthermore, a competent midwife would not only make sure that the placenta is examined correctly, but would also ensure that the placenta is examined in the presence of the mother, having findings continuously being communicated and explained. Any competent assessment of the risk would have to take in account the post birth vital signs of the women.

The midwife's failure to document correctly, take action and evaluate the mother's vital signs was a direct cause towards the deterioration of the mother (Dimond, 2002).

### Conclusion

The professional care provided by the midwife should be based on research and be within the law. As the claims for compensation continue to rise, the need for midwives to understand and reflect on the cases of negligence is important; so as to minimize the risk of negligence and increase the levels of standards of care (Dimond, 2002 pg. 226). It is the midwives' duty to understand the elements of negligence and take care of their actions and behaviours. A holistic approach of care provided by the midwife includes "leadership; clinical knowledge and skills; documentation; guideline development; risk management and debrief; audit; and education" (De Kock, 2004).

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